providers and we searched for addresses using the CMS online database. On March 25, 2019, the high prescribers were sent a hard copy letter from the Massachusetts Department of Public Health stating that they were "among the 1% of frequent prescribers." In addition, the letter provided citations to professional guidelines and prescribing best practices and invited participation in health department–sponsored training for continuing education credits. We tracked the monthly number of antibiotics prescribed by provider before and after the mailing and compared those who received the letter (intervention) to those whose address was either out of state or undeliverable (comparison). **Results:** Prescribing records for 3,008 dentists were available from September 2018 through July 2019. Most (67%) prescribed <10 antibiotic courses in the 11-month period; the mean monthly antibiotic courses prescribed ranged from 1.2 to 1.6, and the median monthly prescriptions was 0. However, 33% prescribed 10–199 antibiotics, and 1% prescribed >200. Of these 28 comprising the highest 1% , 15 received the intervention letter. The others were either out of state (N = 3) or the letter was returned undelivered (N = 10). The average monthly number of antibiotic courses prescribed before the intervention was similar in the intervention and comparison groups (25.0 and 24.2, respectively). In the 4 months after the intervention, the average did not change in the intervention group but increased slightly in the comparison group (25.2 and 26.2, respectively). The intervention had no significant effect ($P = .80$). **Conclusions:** We observed no effect of this peer comparison message among a small sample of dentists in the Massachusetts Medicaid program. This finding may be due to multiple factors, including the small number of the targeted prescribers, the use of a relatively friendly message for communicating with the high prescribers, and the possibility that other forms of communication would be more effective.

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Healthcare Professionals Perception of Mobile Phone Usage and Hand Hygiene Adhesion in Intensive Care Units

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Background: The introduction of new technologies into the medical field has the duality of improvement and concerns about correct usage and cleaning. Mobile phones are used by healthcare professionals (HCPs) in the work place, and there is not an official policy about their use in health environment. **Methods:** We asked 60 intensive care unit (ICU) HCPs from 2 units (the burn unit and the internal medicine unit) to participate in an electronic survey about mobile phone usage and hand hygiene compliance; we also cultured the hands and mobile phones of the participants. Unfortunately, 13 HCPs did not participate. Susceptibility testing of the strains was conducted, as well as molecular testing. **Results:** Overall, 47 HCPs responded to the inquiry: 19% were nurses (9 of 47), 19% were resident physicians (9 of 47), 17% were nursery technicians (8 of 47), 17% were physiotherapists (8 of 47), 13% were cleaning staff (6 of 47), 11% were consultants (5 of 47), and 4% were technicians (2 of 47). Moreover, 26 of 47 participants (55%) were woman and 21 (45%) were men. From all HCP categories, 39 of 47 respondents (83%) reported that they had optimal hand hygiene compliance. However, 92% of respondents had a colonized hand and 90% had a colonized mobile phone. Also, 44 of 47 HCPs (94%) reported that the took their personal mobile phone into the workplace; 40 (85%) reported that they used it during the work day and 35 (74%) reported that they cleaned it. However, 8 HCPs (26%) reported that they had never cleaned the device. All of the HCPs understood that mobile phones can harbor bacteria, and 27 of 47 HCPs (57.45%) indicated that they use 70% alcohol to clean their mobile phones. In contrast, the first choice for hand hygiene was water and soap in 51% of HCPs (24 of 47). Also, 3 HCPs did not have any colonization in the hand culture but had healthcare-associated infection (HAI) pathogens in the mobile phone culture. **Conclusions:** A policy regarding mobile phone usage in the healthcare setting should be in place, and cleaning of electronic devices in hospitals should be standardized.

Table1.- Microorganisms isolated accordingly with the Health-care Professional category and Heath Associated Infections (HAI)

Health-care Professional Category	Hand HAIs Agents	Mobile Phone HAIs Agents	*A.baumanni* Hand Culture	*E.faecalis* Hand culture	*S.aureus* Hand Culture	*S.aureus* Mobile Phone
Nurse	55,56% (5/9)	22,22% (2/9)	33,33% (3/9)	33,33% (3/9)	0% (0/9)	22,22% (2/9)
Cleaning staff	66,67% (4/6)	0% (0/6)	50% (3/6)	16,67% (1/6)	0%(0/6)	0% (0/6)
Physioterapist	25% (2/8)	37,50% (3/8)	0% (0/8)	12,50% (1/8)	0%(0/8)	25% (2/8)
Consultant	60% (3/5)	0% (0/5)	20% (1/20)	0% (0/8)	20%(1/5)	0% (0/5)
Resident	22,22% (2/9)	22,22%(2/9)	11,11% (1/9)	0% (0/9)	11,11%(1/9)	22,2% (2/9)
Nursery technician	37,50% (3/8)	25% (2/8)	0% (0/8)	12,50% (1/8)	12,50% (1/9)	0% (0/8)
Radiologist technician	100% (2/2)	50% (1/2)	50% (1/2)	100% (2/2)	50% (1/2)	50% (1/2)

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Perceptions of Antimicrobial Stewardship among Infectious Disease Physicians at Two Affiliated Teaching Hospitals

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Background: Two affiliated teaching hospitals in Chicago, Illinois, participated in an ethnographic study of hospital-based inpatient antimicrobial stewardship programs and interventions between 2017 and 2018. Although antimicrobial stewardship is now a requirement in medical practice, it is not clear how infectious disease physicians perceive and understand antimicrobial stewardship. Over a period of 18 months, we directly observed infectious disease practice to better understand how antimicrobial stewardship is conducted among physicians within the same specialty. **Methods:** A doctoral candidate medical anthropologist conducted semistructured interviews with infectious disease attending